Broken or cancelled appointments

Patient Name:_____ Birthdate: _____

Your appointment time is valuable and has been reserved specifically for you. If you need to cancel an appointment, please notify us **atleast 72 hours in advance** for Tuesday through Friday appointments and no later than 2:00 pm Thursday for Monday appointments. We charge **$50.00** for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give 72 hours notice so we can discuss this with you.

If you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the dentist's schedule can still accommodate you.

Signature of patient or responsible person I acknowledge and understand the cancellation policy

X_____ *Date:* _____

Insurance and Financial Agreement: Our practice is in-network for most dental insurance carriers, and we are a PPO provider. Please provide your insurance card on your first visit, and let us know of changes in coverage or carriers on subsequent visits. As a courtesy, our office files all necessary paperwork with your insurance company; our friendly staff will be happy to help you maximize your dental benefits. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost.

At the time of service, you will need to pay us the expected estimated insurance deductible and any estimated amount that we expect your insurance will not cover. Remember that many procedures may not be fully covered; in those instances, you are responsible for the remaining amount. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated.

Before proceeding with treatment, we will provide a written estimate of fees, however we try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits. Also, some companies take care of claims promptly while others delay payment for several months. After 60 days from the treatment day if payment is not received from your insurance, the payment will be due in full from you and the insurance company will be reimbursing you. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

We want you to feel comfortable and confident in all aspects of our practice. Remember we do not treat according to your insurance we treat you as an individual and care about your dental health and are dedicated to providing the best treatment available to our patients.

Please be aware: **Full payment** is due at the time of service for the Initial Emergency, Limited appointments or New Patient appointments that are scheduled on the same day of your visit. However, the insurance claim will be submitted as a courtesy to you and allow the insurance company to reimburse you for that visit.

I have read, understand and agree to the above financial agreement. Any questions and concerns were answered fully to my satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner in order to avoid any additional charges. I, the undersigned (patient or legally responsible party) hereby assume all financial responsibilities for treatment rendered. Furthermore, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Bliss Dental. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interests, court cost and attorney fees, which may be added to my balance.

I agree to the above policies and charges.X _____ Date: _____

Signature of patient or responsible person